RECORDS RELEASE

SW FLORIDA OBGYN, LLC
15641 New Hampshire Court
Fort Myers, FL 33908

Patient Name _____ Home Phone_____
Address _____ Cell Phone _____
City_____ State _____ Zip_____ Work Phone _____
Date of Birth _____

Requesting Medical Records From:

SW Florida OBGYN, LLC
15641 New Hampshire Ct.; Ft. Myers, FL 33908
(239)-275-4300 / FAX (239)-275-1870
Please request at least 2 weeks in advance.

Please ____ Fax Records ____ Mail Records

Records to be sent (please check those that apply):
__ Entire Record which includes, but not limited to the following:
__ Surgery Reports __ Pathology Reports and Biopsies
__ Progress Notes __ Ultrasound/Radiology Reports or films
__ Discharge Summary
__ Pap Smears __ Sexually Transmitted Disease Results Including
__ Laboratory work HIV or AIDS Testing
__ Psychological or Psychiatric Notes or Treatments
__ Substance Abuse Treatments
__ Records from any other treating or consulting physicians or nurses

Please Send My Medical Records To:

Name_____ Work Phone_____
Address_____ Fax_____
City_____ State_____ Zip_____

This information is being disclosed for transferring medical care. I have chosen to transfer my care and accept full responsibility in continuing care. I hereby authorize the disclosure of my medical information by Dr. Murray and his practice. Unless specified below, this authorization will expire 6 months from the date signed below. I also understand copying charges of $1 per page up to 25 and then .25 cents per page thereafter plus postage.

Signature_____ Date_____